

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 2 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. |
|---|-------------------------|---|---|---|------------------|---|--|---|--|----------|
| 1. DECEASED NAME (TYPE OR PRINT) Edward L. DRUMMOND | | | | | | 2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 5-26-84 | | 2b. HOUR 10A | | |
| 3. SEX Male | 4. RACE Negro | 5. DATE OF BIRTH (MONTH DAY YEAR) Nov. 23 1912 | 6. AGE (IN YEARS) LAST BIRTHDAY 71 YRS. | IF UNDER 1 YR. MONTHS DAYS HOURS MIN | IF UNDER 24 HRS. | 2c. DATE PRONOUNCED DEAD 5-26-84 19 | | 2d. HOUR 9 P | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Va. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Worcester | | | | |
| 10. CITY OR TOWN OF DEATH Pocomoke | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Rt. 1, Box 279 | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer | | 12b. KIND OF BUSINESS OR INDUSTRY Carpenter | | |
| 13a. STATE Md. | | 13b. COUNTY Worcester | | 13c. CITY OR TOWN Pocomoke | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS Rt. 1 Bx. 279 21851 | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Unknown | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Inez Maddox | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES) Yes WW II | | 16b. SOCIAL SECURITY NO. 217-05-0768 | | 17. INFORMANT Dorothy Cropper | | ADDRESS 1117 So. 60th St. Phila., Pa. 19143 | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 4100 IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Pending | | | | | | | | | | |
| ACTUAL SIGNATURE <i>Earl L. Royer</i> | | TITLE (SPECIFY) Deputy | | | | DATE SIGNED 5-29-84 | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Earl L. Royer, M.D. | | ADDRESS 409 Camden Ave., Salisbury, Md. | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 6-2-84 | | 23c. NAME OF CEMETERY OR CREMATORY Johnson Neck Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Pocomoke Worcester Md. | | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS Savage Funeral Home, New Church, Va. | | | | 25a. DATE OF RECORD JUN 7 1984 | | 25b. REGISTRAR'S SIGNATURE <i>Juha Davidson-Randall</i> | | | | |



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-copy pages 4 and 5 and return them to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner will be notified and advised.

DHMM - 16 50M1/81
(VRA 15, 4)

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|--|--|---|--|--|--|---|--|
| 1. FOR STATE REGISTRAR | | REG. NO. 8414898 | | | | | | | |
| I DECEASED NAME (TYPE OR PRINT) VIOLET C. EWELL | | 2a. DATE OF DEATH MONTH DAY YEAR May 5, 1984 | | 2b. HOUR 3:00 P | | | | | |
| 3. SEX FEMALE | | 4. RACE WHITE | | 5. DATE OF BIRTH Feb. 8, 1911 | | 6. AGE (IN YEARS LAST BIRTHDAY) 73 | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Worcester MD. | | | |
| 10. CITY OR TOWN OF DEATH W. Ocean Ctiy | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) P.O. Box 338 C Savage Rd, | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE Maryland | | 13b. COUNTY Worcester | | 13c. CITY OR TOWN W. Ocean City | | 13d. INSIDE CITY LIMITS? <input type="checkbox"/> NO <input checked="" type="checkbox"/> YES | | 13e. STREET ADDRESS P.O. Box 338 C- W. Ocean City, MD | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Sidney G. Crew | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nettie E. Washbourn | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 216 48 5905 | | 17. INFORMANT ADDRESS Coastal Hospice, Ocean City, MD | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Motile Carcinoma of Ovary DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Carcinoma of Ovary DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Arteriosclerotic Cardiovascular Disease - Est M.D. + C.L.A. | | | | | | | | | |
| 19a. DATE OF OPERATION None | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from April 17, 1984 to date , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If) (we) (did) not view the body after death. | | | | | | | | | |
| 22b. SIGNATURE H. R. Mann, Jr. | | DEGREE J. MD. | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 5-2-84 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Hunter R. Mann, Jr. | | 22e. ADDRESS 10th St. & N. Phil. Ave., OC, MD | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 5/10/84 | | 23c. NAME OF CEMETERY OR CREMATORY Evergreen Cemetery Berlin | | 23d. LOCATION CITY OR TOWN COUNTY STATE Worcester, MD | | | |
| 24. FUNERAL DIRECTOR NAME Anna A. Burbage | | 108 Williams St. Berlin, MD 21811 | | 25a. DATE RECD. BY REGISTRAR MAY 11 1984 | | 25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall | | | |

MEDICAL CERTIFICATION

VIOLAT C. BAXELL MAY 2, 1984 3:00 P

THURSDAY WITH FEB. 8, 1981 73

MARYLAND USA X HONOLULU

W. Ocean City P.O. Box 338 C Savage Rd, Honolulua
W. Ocean City, MD

Maryland Worcester W. Ocean City P.O. Box 338 C W. Ocean City

SEVEN F. GROVE TOTTEN W. WASHINGTON

NO RIC 66 8265 Coastal Highway, Ocean City, MD

[Faint, illegible text and markings, possibly a large stamp or faded print, covering the middle section of the page.]

11. Printer A. Hill, CT. 100 St. A. Hill, Ave., CT, 06

Postal 5/10/84
108 Williams St.
Zone 1. Bridge Berlin, MD 21811
MAY 11 1984
Riverside County Berlin, Worcester, MD

#18, 21, 22, Film 592 6/28/84 STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 4 3 9 9

| | | | | | | | | | | | | | |
|--|--|----------------------|--|---|--|---|--|--|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) TIMOTHY LEE FISHER | | | | | | | | | | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR 5-20-84 | | 2b. HOUR 10AM | |
| 3. SEX Male | | 4. RACE Negro | | 5. DATE OF BIRTH MONTH DAY YEAR July 14/1963 | | 6. AGE (IN YEARS) (LAST BIRTHDAY) 20 YRS. | | IF UNDER 1 YR. MONTHS DAYS HOURS MIN. | | 2c. DATE PRONOUNCED DEAD 5-20-84 | | 2d. HOUR 10AM | |
| 7a. BIRTHPLACE - (STATE OR FOREIGN COUNTRY) Md. | | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Worcester County MD. | | | |
| 10. CITY OR TOWN OF DEATH Pocomoke | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Pocomoke River Cypress Park | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer | | 12b. KIND OF BUSINESS OR INDUSTRY Factory | |
| 13a. STATE Md. | | | | 13b. COUNTY Somerset | | | | 13c. CITY OR TOWN Marion | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 243 Bevins Lane | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Howard R. Fisher, Jr. | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Mae Costen | | | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No (IF YES, GIVE WAR OR DATES) 216-86-9070 | | | | | |
| 16a. SOCIAL SECURITY NO. 216-86-9070 | | | | 17. INFORMANT Howard R. Fisher, Jr. | | | | 17a. ADDRESS 243 Bevins Lane Marion, Md. | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Drowning with Blunt force trauma to head Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) to head DUE TO, OR AS A CONSEQUENCE OF (c) 9640 | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR ? P.M. 5/19 1984 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) Subject apparently assaulted | | | | | |
| 21d. INJURY OCCURRED WHILE <input checked="" type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Park | | | | 21f. LOCATION CITY OR TOWN COUNTY STATE Cypress Park, Pocomoke, Wor.Co., Md. | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input checked="" type="checkbox"/> . Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | |
| ACTUAL SIGNATURE Margarita A. Korell | | | | TITLE (SPECIFY) Assistant | | | | DATE 5-22-84 | | | | SIGNED | |
| EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D. | | | | ADDRESS 111 Penn Street | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE 5-26-84 | | | | 23c. NAME OF CEMETERY OR CREMATORY Trinity U.M. Cemetery | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Pocomoke Wor. Md. | |
| 24. FUNERAL DIRECTOR NAME Samuel H. George | | | | ADDRESS New Church, Va. | | | | JUN 11 1984 | | | | | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201



1. The first part of the paper is devoted to a discussion of the general principles of the theory of the structure of the atom. It is shown that the theory of the structure of the atom is a special case of the more general theory of the structure of the molecule. The theory of the structure of the molecule is a special case of the more general theory of the structure of the crystal. The theory of the structure of the crystal is a special case of the more general theory of the structure of the solid. The theory of the structure of the solid is a special case of the more general theory of the structure of the liquid. The theory of the structure of the liquid is a special case of the more general theory of the structure of the gas. The theory of the structure of the gas is a special case of the more general theory of the structure of the plasma. The theory of the structure of the plasma is a special case of the more general theory of the structure of the universe.



2. The second part of the paper is devoted to a discussion of the general principles of the theory of the structure of the molecule. It is shown that the theory of the structure of the molecule is a special case of the more general theory of the structure of the crystal. The theory of the structure of the crystal is a special case of the more general theory of the structure of the solid. The theory of the structure of the solid is a special case of the more general theory of the structure of the liquid. The theory of the structure of the liquid is a special case of the more general theory of the structure of the gas. The theory of the structure of the gas is a special case of the more general theory of the structure of the plasma. The theory of the structure of the plasma is a special case of the more general theory of the structure of the universe.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 must be retained by the hospital or attending physician.

DHMH-1650M 1/81
(VRA 15, 4)

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1, 2, and 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|--|--|--|---|---|------------------|---|--|
| 1 - FOR STATE REGISTRAR | | | | | 84 REG. NO. 14900 | | | | |
| 1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ESTELLA CATHERINE HUDSON | | | | | 2a DATE OF DEATH MONTH DAY YEAR MAY 5, 1984 | | | 2b HOUR 1:30P M | |
| 3 SEX FEMALE | | 4 RACE WHITE | | 5 DATE OF BIRTH DAY MONTH YEAR JULY 1, 1891 | | 6 AGE (IN YEARS LAST BIRTHDAY) 92 YRS | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Delaware | | 7b CITIZEN OF WHAT COUNTRY? USA | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH WORCESTER MD. | | | |
| 10 CITY OR TOWN OF DEATH BERLIN | | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 113 West St., Berlin, MD | | | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b KIND OF BUSINESS OR INDUSTRY | |
| 13a STATE Maryland | | 13b COUNTY Worcester | | 13c CITY OR TOWN Berlin | | 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e STREET ADDRESS 113 West St., Berlin, MD | |
| 14 FATHER'S NAME FIRST MIDDLE LAST Joshua Parker | | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Isabelle Baker | | | 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO | | | |
| 16b SOCIAL SECURITY NO. 213 74 1693 | | | 17 INFORMANT ADDRESS Mrs. Turner Dennis Berlin, MD | | | | | | |
| 18 CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 4409 IMMEDIATE CAUSE (a) Congestive heart failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Auto heart failure | | | | | | | | | |
| 19a DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/19 , 19 81 , to 5/5 , 19 84 , that (I) (we) last saw the deceased alive on 5/5 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Joseph Z. Badros MD | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Joseph Z. Badros | | | | 22e. ADDRESS 229 Florida Ave., Salisbury, MD 21801 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 5/8/84 | | 23c. NAME OF CEMETERY OR CREMATORY Millsboro Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Millsboro, DE | | | |
| 24 FUNERAL DIRECTOR NAME Anna A. Burbage | | | | 108 Williams St. Berlin, MD 21811 | | 25a. DATE RECEIVED BY REGISTRAR 25b. REGISTRAR'S SIGNATURE MAY 11 1984 Julia Davidson-Randall | | | |

WETZEL CATHETER HUNTER MAY 2, 1904 1:30P

WETZEL JUNE 1, 1904 92

WETZEL 102

WETZEL 113 West St., Berlin, MD

WETZEL 113 West St., Berlin, MD

WETZEL 113 West St., Berlin, MD

WETZEL 113 West St., Berlin, MD

Handwritten notes and signatures, including "Dr. Joseph E. Edwards" and "Wetzel".

212

Dr. Joseph E. Edwards

212 Florida Ave., Salisbury, MD 21801

Wetzel 113 West St., Berlin, MD

Wetzel 113 West St., Berlin, MD

Wetzel 113 West St., Berlin, MD

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carboncopiers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified (see page 1).

FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

84 REG. NO. 14901

| | | | | | | | | | |
|--|--|--|--|--|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) Mildred M. Hudson | | | 2a. DATE OF DEATH MONTH DAY YEAR 5 15 84 | | | 2b. HOUR 12:05 M | | | |
| 3 SEX Female | | 4 RACE WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR 2 11 06 | | 6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Delaware | | 7b CITIZEN OF WHAT COUNTRY? USA | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Worcester County MD. | | | |
| 10 CITY OR TOWN OF DEATH Berlin, MD. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Berlin Nursing Home | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE MARYLAND | | 13b. COUNTY | | 13c. CITY OR TOWN BISHOPVILLE | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS ST. MARTINS P.O. BOX 304 NECK RD. | |
| 14 FATHER'S NAME FIRST MIDDLE LAST LEVIN J. MAGEE | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lilly Magee | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | | 16b. SOCIAL SECURITY NO. 222-05-7026 | | 17. INFORMANT ADDRESS | | | |

| | | |
|---|--|--|
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4409 IMMEDIATE CAUSE (a) Cardio Respiratory Arrest DUE TO, OR AS A CONSEQUENCE OF ASVD. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF Aging. (c) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|--|--|

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from April 25 1984, to May 14 1984, that (I) (we) lost saw the deceased alive on May 14 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE M.D. | | 22c. DATE SIGNED 5.15.84 | | | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Federico Arthes, M.D. | |
| 22e. ADDRESS 3 Bay St., Berlin, Md. 21811 | | | | | | | |

| | | | | | | | |
|--|--|-------------------------|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE MAY 17, 84 | | 23c. NAME OF CEMETERY OR CREMATORY ODD BELL OWS | | 23d. LOCATION CITY OR TOWN COUNTY STATE BISHOPVILLE MD. | |
| 24 FUNERAL DIRECTOR NAME A. DOUGLAS MELSON ADDRESS MELSON FUNERAL SERVICES FRANKFORD, DE | | | | 25a. DATE REC'D. BY REGISTRAR MAY 25 1984 | | 25b. REGISTRAR'S SIGNATURE Lila Davidson-Rendell | |

1

Charles E. Bunker, Trust

ALVA

ALVA

ALVA 18 1914

ALVA 18 1914

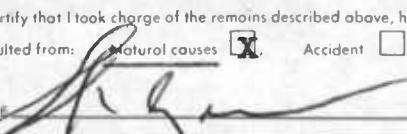

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

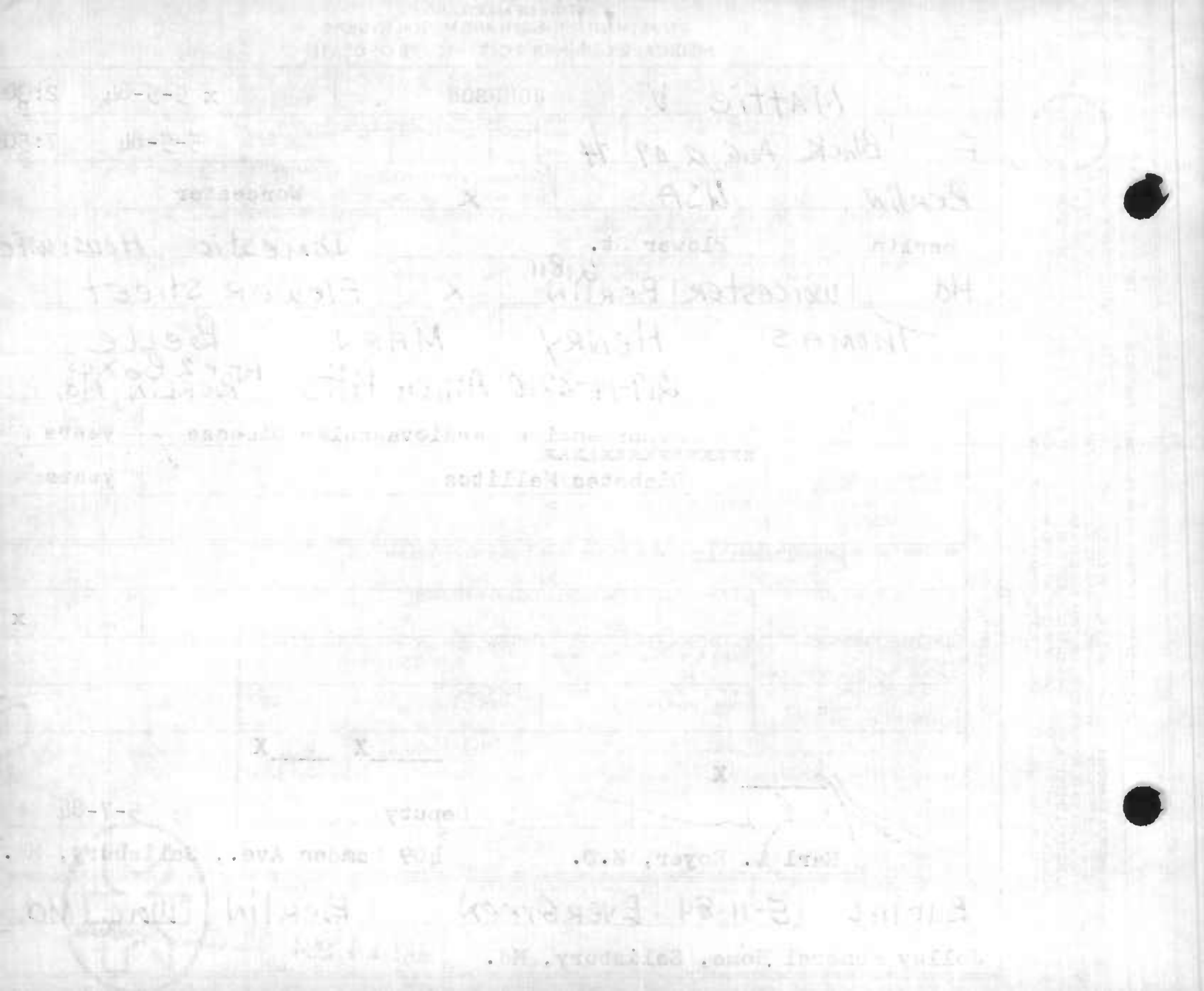
BP

DHMH - 17
(VR A15 ME (5))
20M 4/B2

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 4902

| | | | | | | | | | | | | | |
|---|----------------------|---|--|--|---|--|--|--|--|--|--|------------------|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | 2a. DATE KNOWN OF DEATH | | 2b. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) Mattie V. JOHNSON | | | | | | | | | | ESTIMATED <input checked="" type="checkbox"/> 5-5-84 | | 2b. HOUR 2:30 PM | |
| 3. SEX F | 4. RACE Black | 5. DATE OF BIRTH (MONTH DAY YEAR) AUG 12 09 74 | 6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS. | IF UNDER 1 YR. MONTHS DAYS HOURS MIN. | IF UNDER 24 HRS. MONTHS DAYS HOURS MIN. | 2c. DATE PRONOUNCED DEAD 5-5-84 | | 2d. HOUR 7:50 PM | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Berlin | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Worcester MD. | | | | | | | |
| 10. CITY OR TOWN OF DEATH Berlin | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Flower St. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Domestic | | 12b. KIND OF BUSINESS OR INDUSTRY Housewife | | | | | |
| 13a. STATE MD. | | 13b. CITY Worcester | | 13c. CITY OR TOWN Berlin | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS Flower street | | | | | |
| 14. FATHER'S NAME (FIRST MIDDLE LAST) THOMAS HENRY | | | | 15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST) MARY Belle | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | | | 16b. SOCIAL SECURITY NO. 219-14-3210 | | 17. INFORMANT Athen Pitts ADDRESS Rt # 2 Box 48 Berlin, Md. | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 4029 IMMEDIATE CAUSE (a) Hypertensive Cardiovascular Disease XXXXXXXXXXXX Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost: (b) Diabetes Mellitus DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH years years | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion | | | | | | | | | | | | | |
| ACTUAL SIGNATURE  | | | | TITLE (SPECIFY) Deputy M.D. MEDICAL EXAMINER | | | | DATE SIGNED 5-7-84 | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Earl L. Royer, M.D. | | | | ADDRESS 409 Camden Ave., Salisbury, Md. | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 5-11-84 | | 23c. NAME OF CEMETERY OR CREMATORY EverGreen | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Berlin Worcester Md. | | | | | |
| 24. FUNERAL DIRECTOR NAME Jolley Funeral Home, Salisbury, Md. | | | | 25a. DATE REC'D BY REGISTRAR MAY 14 1984 | | | | 25b. REGISTRAR'S SIGNATURE  | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | |
|--|--|--|--|--|------------------------------------|--|---|--|--|------------------|
| 1. FOR STATE REGISTRAR | | 8 4 REG. NO. 1 4 9 0 3 | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | | 2a. DATE OF DEATH | | | 2b. HOUR | | |
| JULIA Quillen JONES | | | | | 5 26 84 | | | 12 55 P.M. | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | 7. IF UNDER 1 YEAR | | |
| Female | | Caucasian | | 01 20 1897 | | 87 YRS. | | MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | |
| Virginia | | U. S. | | | | Worcester MD. | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Pocomoke City | | Hartley Hall Nursing Home | | | | Housewife | | Self | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | |
| Virginia | | Accomac | | Chincoteague | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 124 Mumford Street 99999 | | |
| 14. FATHER'S NAME | | | | | 15. MOTHER'S MAIDEN NAME | | | | | |
| John William Colona | | | | | Virginia Elizabeth Parks | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | | | | |
| no | | 223-92-5949 | | Hilda Berry, Chincoteague, Virginia | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| IMMEDIATE CAUSE (a) Metastatic Renal Cell Carcinoma. | | | | | | | | | | |
| 1890 DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2) | | | | |
| | | | HOUR A.M. MONTH DAY YEAR | | | | | | | |
| 21d. INJURY OCCURRED | | | 21e. PLACE OF INJURY | | | 21f. LOCATION | | CITY OR TOWN COUNTY STATE | | |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | STREET | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Feb 19 84 to May 25 19 84, that (I) (we) last saw the deceased alive on 19 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE | | | | | | | | DEGREE | | 22c. DATE SIGNED |
| Paul R Fleury MD | | | | | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 5/27/84. |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | | 22e. ADDRESS | | | | |
| PAUL R FLEURY | | | | | | 305 TENTH ST. | | | | |
| 23a. BURIAL, CREMATION, REMOVAL | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION | | |
| Burial | | | 5-29-84 | | Mechanics Cemetery | | | Chincoteague, Virginia | | |
| 24. FUNERAL DIRECTOR | | | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | |
| Gene S. Salys Chincoteague, Virginia | | | | | | JUN 4 1984 | | [Signature] | | |



Miller

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial transit permit. Then please remove carbon-copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|---|--|---|--|---|--|---|---|
| 1. FOR STATE REGISTRAR | | 84 REG. NO. 14904 | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | | | 2a. DATE OF DEATH | | 2b. HOUR | |
| Viola M. Merritt | | | | | | 5 16 84 | | 8:30 A M | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | 8. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| Female | | White | | 10 9 97 | | 86 YRS | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| Maryland | | USA | | | | Worcester County MD. | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Berlin, Md. | | Berlin Nursing Home | | | | Housewife | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. STREET ADDRESS | | | |
| Maryland | | Worcester | | Berlin | | Rt. 4, Box 204 21811 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | | | |
| John Pruitt | | | | Rose Unknown | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) | | 17. INFORMANT ADDRESS | | | | | |
| No | | 214-14-2977 | | Berlin Nursing Home, Berlin, MD | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio Pulmonary Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>ASUD.</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Aging.</u> | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>JAN 83</u> , 19 <u>83</u> , to <u>MAY 84</u> , 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>MAY 15</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <u>Federico Arthes</u> M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | | | 22c. DATE SIGNED 5-17-84 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Federico Arthes, MD | | | | | | 22e. ADDRESS 3 Bay St., Berlin, Md. 21811 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | 23e. DATE REC'D. BY REGISTRAR | |
| BURIAL | | 5/20/84 | | Beth Eden | | Snow Hill, Worcester, MD | | MAY 23 1984 | |
| 24. FUNERAL DIRECTOR NAME | | | | | | 25a. REGISTRAR'S SIGNATURE | | | |
| ANNA A. BURBAGE Berlin, MD 21811 | | | | | | Lia Davidson-Rendall | | | |

MEDICAL CERTIFICATION



Unknown

Post

Post

John

214-14-227 Berlin Nursing Home, Berlin, MD

Charles Frederick Jones

1910

1910



1910 - 1910 - 1910

2-11-84

W.P. &

Handwritten signature or initials.

Chow Hill, Worcester, MA

106 Williams Street

106

106 Williams Street

106 Williams Street

106 Williams Street

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| 1. FOR STATE REGISTRAR | | STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | REG. NO. 14905 | |
|--|--|---|---|--|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST FLORENCE S. MURPHY | | | 2a. DATE OF DEATH MONTH DAY YEAR 5 12 1984 | | 2b. HOUR 12:40^a |
| 3. SEX FEMALE | 4. RACE WHITE | 5. DATE OF BIRTH MONTH DAY YEAR 9-11-1904 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS HOURS MIN. 79 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.Y. | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH WORCESTER MD. | |
| 10. CITY OR TOWN OF DEATH BERLIN, MD. | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BERLIN NURSING HOME | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) AT HOME | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE N.Y. | | 13b. COUNTY WESTCHESTER | 13c. CITY OR TOWN DOBBS FLY. | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST SYLVESTER L. STORMS | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST JENNIE L. STORMS | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO | | 16b. SOCIAL SECURITY NO. 082-38-8101 | | 17. INFORMANT ADDRESS M. M. CLARK BERLIN MD | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4409 Cardio Respiratory Arrest. DUE TO, OR AS A CONSEQUENCE OF (b) ASVD. DUE TO, OR AS A CONSEQUENCE OF (c) AGING. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from Jan 83 to May 84 , that (I) (we) last saw the deceased alive on May 10 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE OF PHYSICIAN Federico Arthes M.D. | | | | 22c. DATE SIGNED 5-12-84 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) FEDERICO ARTHES, M.D. | | 22e. ADDRESS 3 BAY STREET, BERLIN, MD. 21811 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREM | | 23b. DATE 5/14/84 | 23c. NAME OF CEMETERY OR CREMATORY DELMARVA | | 23d. LOCATION CITY OR TOWN COUNTY STATE KEWES, SUSSEX, DEL. |
| 24. FUNERAL DIRECTOR NAME WILKINSON F.H. | | 24b. ADDRESS BERLIN, MD. | | 25a. DATE REC'D. BY REGISTRAR MAY 16 1984 | |



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|---|---|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | | REG. NO. 14906 | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ISSAC J. PURNELL | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 5 22 84 | | | | |
| 3. SEX MALE | | | | | 2b. HOUR 5:09 P.M. | | | | |
| 4. RACE Negro | | 5. DATE OF BIRTH MONTH DAY YEAR 4 1 1907 | | 6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS. | | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH WORCESTER MD. | | | |
| 10. CITY OR TOWN OF DEATH BERLIN, MD. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BERLIN NURSING HOME | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer | | 12b. KIND OF BUSINESS OR INDUSTRY Feed Co. | | |
| 13a. STATE Maryland | | 13b. COUNTY Worcester | | 13c. CITY OR TOWN Snow Hill | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 13e. STREET ADDRESS 202 E. Martin St. -- 21863 | | | | | | | | | |
| 4. FATHER'S NAME FIRST MIDDLE LAST Martin Purnell | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Myrtle Unknown | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES | | | | | 16b. SOCIAL SECURITY NO. 216-09-6150 | | | | |
| 17. INFORMANT ADDRESS Eleanora F. Purnell, Snow Hill, Md. | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4409 IMMEDIATE CAUSE (a) <u>Cardio respiratory Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>ASVD</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Aging</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>May 19 84</u> to <u>May 19 84</u> , that (I) (we) lost saw the deceased alive on <u>May 19 84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <u>Federico Arthes</u> | | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED 5-2-84 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) FEDERICO ARTHES, M.D. | | | | | 22e. ADDRESS 3 BAY ST., BERLIN, MD. | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 5/26/84 | | 23c. NAME OF CEMETERY OR CREMATORY Mt. Zion Baptist | | 23d. LOCATION CITY OR TOWN COUNTY STATE Snow Hill, Maryland | | |
| 24. FUNERAL DIRECTOR NAME Norman F. Dennis | | | | | ADDRESS Snow Hill, Maryland | | 25. DATE RECD. BY REGISTRAR MAY 25 1984 | | |
| | | | | | 26. REGISTRAR'S SIGNATURE <u>Fida Davidson-Randall</u> | | | | |



Central Engineering Agency

1947-1948

BOX 1011

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Handwritten signature or name.

May 25 1948

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked WHILE AT WORK, the medical examiner must be notified.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | |
|---|--|--|--|---|---|---|---------------------------------------|--|---|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Elwood R. Pusey | | | | | 2a. DATE OF DEATH MONTH DAY YEAR May 31, 1984 | | 2b. HOUR 9:30P_M | | | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR October 14, 1913 | | 6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS. | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. IF UNDER 24 HRS. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Worcester MD. | | | | |
| 10. CITY OR TOWN OF DEATH Snow Hill | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 118 Stevens Street | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Salesman | | 12b. KIND OF BUSINESS OR INDUSTRY Furniture | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland | | | | | 13b. COUNTY Worcester | | 13c. CITY OR TOWN Snow Hill | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST I. Elmer Pusey | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elnora Tull | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 216 07 6240 | | 17. INFORMANT ADDRESS Lillian B. Pusey, Snow Hill, Maryland | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4275 IMMEDIATE CAUSE (a) CARDIAC ARREST DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH IMMEDIATE | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS, CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) META-STATIC CA OF LUNG, ABDOMINAL ANEURYSM | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) <u>(the hospital)</u> attended the deceased from <u>FEB 21</u> , 19 <u>74</u> , to <u>MAY 31</u> , 19 <u>84</u> , that (I) <u>(was)</u> lost saw the deceased alive on <u>APRIL 12</u> , 19 <u>84</u> , and that in (my) <u>(my)</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>(did)</u> <u>(did not)</u> view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE Dorothy C. Holznorth | | DEGREE M.D. | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED 5-31-84 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) DOROTHY C. HOLZNORTH | | | | 22e. ADDRESS 309 TIMMONS ST. SNOW HILL, MD. 21863 | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 6/3/84 | | 23c. NAME OF CEMETERY OR CREMATORY Christian | | 23d. LOCATION CITY OR TOWN COUNTY STATE Snow Hill, Worcester, Md. | | | | |
| 24. FUNERAL DIRECTOR NAME Norman F. Dennis | | | | ADDRESS Snow Hill, Maryland | | 25a. DATE REC'D. BY REGISTRAR JUN 6 1984 | | | | |



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1- FOR
STATE
REGISTRAR

REG. NO. 14908

| | | | | | | | | | | | |
|---|--|---|--|---|---|--|---|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MARY MIDDLE Simpson LAST Riggins | | | 2a. DATE OF DEATH MONTH 5 DAY 29 YEAR 84 | | | 2b. HOUR 830A M. | | | | | |
| 3. SEX F | | 4. RACE Cauc. | | 5. DATE OF BIRTH MONTH 8 DAY 13 YEAR 98 | | 6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS | | 8. IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Broadwater VA | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Worcester MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Pocomoke City Md | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 11 2nd St. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY Homemaking | | | |
| 13a. STATE Virginia | | | 13b. COUNTY Northampton | | 13c. CITY OR TOWN Exmore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS Exmore, Va. 23350 | | |
| 14. FATHER'S NAME FIRST James MIDDLE W. LAST Simpson | | | | | | 15. MOTHER'S MAIDEN NAME FIRST Mary MIDDLE Ellen LAST Bradford | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 186-12-4063 | | 17. INFORMANT Richard Tittermary | | | ADDRESS 11 2nd St. Pocomoke City, Md. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u> 4292 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a. | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>JANUARY 1984</u> to <u>MAY 1984</u> , that (I) (we) last saw the deceased alive on <u>JAN. 28</u> 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE <u>Paul R. Fleury</u> | | | | | | DEGREE M.D. | | 22c. DATE SIGNED 5/28/84 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Paul R. Fleury M.D. | | | | | | 22e. ADDRESS 305 TENTH ST Pocomoke City Md | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 5-30-84 | | 23c. NAME OF CEMETERY OR CREMATORY Belle Haven | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Belle Haven Accomack Va | | | |
| 24. FUNERAL DIRECTOR NAME Guy J. Doughty ADDRESS Box 633 Exmore, Va 23350 | | | | | | 25a. DATE REC'D. BY REGISTRAR JUN 1 1984 | | 25b. REGISTRAR'S SIGNATURE <u>Davidson-Randall</u> | | | |



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked as true, it shows city injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 50M 1/81
(VRA 15, 4)

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|--|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) CLARA LOUISE TURNBAUGH | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 5/11/84 | | 2b. HOUR M | |
| 3. SEX FEMALE | | 4. RACE WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR *8 10 1925 | | 6. AGE (IN YEARS LAST BIRTHDAY) 58 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH WORCESTER MD. | | | |
| 10. CITY OR TOWN OF DEATH Ocean City | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Rt. 1, Box 317 BB Maryland | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY Mother | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE Maryland | | | | 13c. CITY OR TOWN Worcester Ocean City | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 21842 Ocean City, Rt. 1, Box 317BB Maryland | |
| 14. FATHER'S NAME FIRST MIDDLE LAST William Robert Haberkorn | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Molly Brown | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 220 14 3058 | | 17. INFORMANT ADDRESS Mr. Archie Turnbaugh, Rt. 1, Box 317 Ocean City, MD | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1629 Substatue lung cancer DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <i>[Signature]</i> | | | | 22c. DATE SIGNED 5/15/84 | | | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Joseph A. Grasso | |
| 22e. ADDRESS 1300 S. Division St., Salisbury, MD 21801 | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE 5/14/84 | | 23c. NAME OF CEMETERY OR CREMATORY Sunset Memorial | | 23d. LOCATION CITY OR TOWN COUNTY STATE Berlin, Worcester, MD | |
| 24. FUNERAL DIRECTOR NAME Anna A. Burbage | | | | 108 Williams St. Berlin, Md 21811 | | DATE REC'D. BY REGISTRAR MAY 17 1984 | | REGISTRAR'S SIGNATURE <i>[Signature]</i> | |

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U.S.A.

RE. J. FOX DIV. 11

St. I, Box 11718

NOTES

[illegible]

12. Joseph A. DiPasquale

1300 E. Division St.,

1612

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Berlin, Worcester, Mass.

Page 10

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | REG. NO. 14910 | |
|---|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST THEODORE F. VESS | | | | 2a. DATE OF DEATH MONTH DAY YEAR 5-5-84 | |
| 3. SEX MALE | | 4. RACE WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR 10-6-06 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VIRGINIA | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN. 77 YRS. | |
| 10. CITY OR TOWN OF DEATH BERLIN | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) N. MAIN ST. | | 9. BALTIMORE CITY OR COUNTY OF DEATH WORCESTER MD. | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) MECHANIC | | 12b. KIND OF BUSINESS OR INDUSTRY FARM | | 13a. STREET ADDRESS N. MAIN ST. | |
| 13a. STATE MD | | 13b. COUNTY WOR | | 13c. CITY OR TOWN BERLIN | |
| 14. FATHER'S NAME FIRST MIDDLE LAST JACOB HENRY VESS | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST SARAH ANNE WOOD | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | |
| 16b. SOCIAL SECURITY NO. 213-01-7361 | | 17. INFORMANT FRED VESS | | ADDRESS DOVER, DEL. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Lung 1629 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 months | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). COPD, Pneumonia | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 4-23-84 to 4-25-84 , that (I) (we) lost saw the deceased alive on 4-23-84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (they) did not view the body after death. | | | | | |
| 22b. SIGNATURE Michael E. Crouch | | DEGREE MD | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Michael E. Crouch | | 22e. ADDRESS 531 Riverside | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 5-9-84 | | 23c. NAME OF CEMETERY OR CREMATORY SUNSET MD. | |
| 23d. LOCATION BERLIN, WOR, MD | | 25a. DATE REC'D. BY REGISTRAR MAY 8 1984 | | | |
| 24. FUNERAL DIRECTOR NAME WILLIAM F. H. BERLIN, MD. | | 25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall | | | |

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Handwritten text, mostly illegible due to fading. The text appears to be a letter or report, possibly dated 1890. The handwriting is in cursive and spans across the page.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health officer with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified on page 4.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|---|--|--|--|---|--|---|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) William F. West Sr. | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR May 2, 1984 | | 2b. HOUR 12:20 P M | |
| 1. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR July 2, 1924 | | 6. AGE (IN YEARS LAST BIRTHDAY) 59 YRS | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Worcester MD. | | | |
| 10. CITY OR TOWN OF DEATH Snow Hill | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Rt. 3 - Box 68 | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Farmer | | 12b. KIND OF BUSINESS OR INDUSTRY Truck Farm | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | |
| 13a. STATE Maryland | | 13b. COUNTY Worcester | | 13c. CITY OR TOWN Snow Hill | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS Rt. 3-Box 68 --- 21863 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Frank P. West | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mattie Mitchell | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No | | | | 16b. SOCIAL SECURITY NO. 215 20 4377 | | 17. INFORMANT ADDRESS Mary N. West Snow Hill, Maryland | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 4360 IMMEDIATE CAUSE (a) Cerebral Vascular Accident DUE TO, OR AS A CONSEQUENCE OF 20 Pericardial Cancer DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE J. H. H. H. | | | | DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED 5/4/84 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 5/5/84 | | 23c. NAME OF CEMETERY Makemie Presbyterian | | 23d. LOCATION CITY OR TOWN COUNTY STATE Snow Hill, Maryland | | | |
| 24. FUNERAL DIRECTOR J. H. H. H. | | | | ADDRESS Snow Hill, Maryland | | 25a. DATE REC'D. BY REGISTRAR MAY 10 1984 | | | |
| 25b. REGISTRAR'S SIGNATURE J. H. H. H. | | | | | | | | | |



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WALKER, WALTER A.

100-1-1000

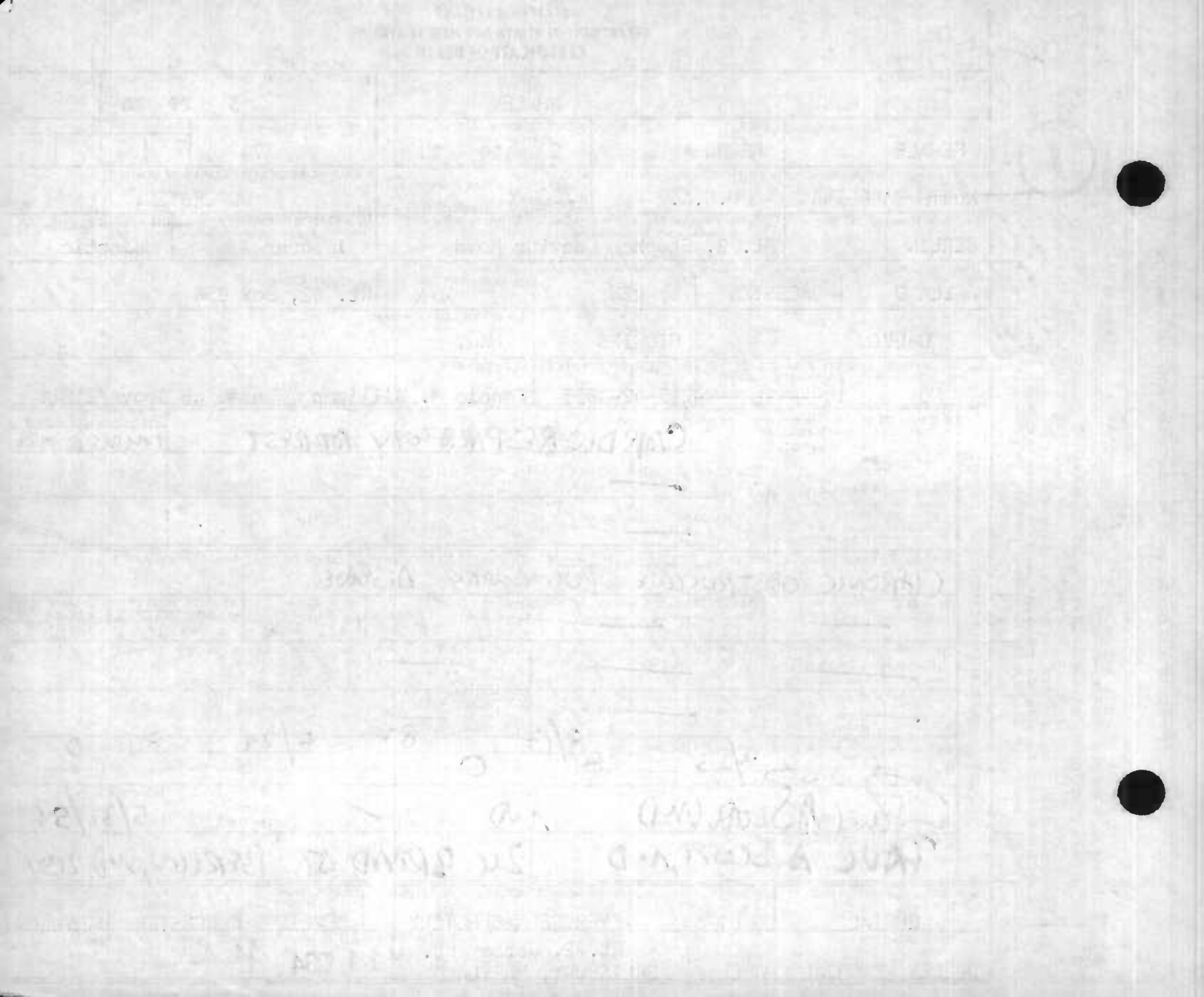
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Page 1 and 2 should be filed within 7 days after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical investigation conducted.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | REG. NO. 1 4 9 1 2 | | | |
|--|--|--|--|---|--|---|---|
| 1. FOR STATE REGISTRAR | | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MARY WHALEY | | | | 2b. HOUR M | | | |
| 3 SEX FEMALE | | 4 RACE NEGRO | | 5. DATE OF BIRTH MONTH DAY YEAR 2 14 10 | | 6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN. 74 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NORTH CAROLINA | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH WORCESTER, MD. | |
| 10. CITY OR TOWN OF DEATH BERLIN | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Rt. #2, Stephen Decatur Road | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) laborer | | 12b. KIND OF BUSINESS OR INDUSTRY domestic | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND 13b. COUNTY WORCESTER 13c. CITY OR TOWN BERLIN | | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS Rt. #2, Box 256 21811 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST CALVIN HIGGINS | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213-42-0857 | | 17. INFORMANT ADDRESS Fannie M. Williams same as above/21811 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4275 CARDIORESPIRATORY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH IMMEDIATE |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) CHRONIC OBSTRUCTIVE PULMONARY DISEASE | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (1) this hospital attended the deceased from 8/17 19 82, to 5/29 19 84, that (2) (we) lost the deceased alive on 3/23 19 84, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death. | | | | | | | |
| 23a. SIGNATURE PAUL A. SCOTT, MD | | | | DEGREE MD | | 22c. DATE SIGNED 5/31/84 | |
| 23b. PHYSICIAN'S NAME (TYPE OR PRINT) PAUL A. SCOTT, MD | | | | 22e. ADDRESS 24 BROAD ST. BERLIN, MD 21811 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 6/01/84 | | 23c. NAME OF CEMETERY OR CREMATORY EVERGREEN CEMETERY | | 23d. LOCATION CITY OR TOWN COUNTY STATE BERLIN WORCESTER MARYLAND | |
| 24. FUNERAL DIRECTOR NAME JOLLEY MEMORIAL CHAPEL | | | | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE JUN 11 1984 John Davidson-Randall | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after the death. The law also requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene. **IMPORTANT:** If item 21 is marked as "I" it shows only injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | REG. NO. | 1 4 9 1 3 | | | |
|--|---|--|--|---|-----------------------------------|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST VIOLA E. WILLIAMS | | | | 2a. DATE OF DEATH MONTH DAY YEAR 5 10 1984 | | 2b. HOUR 7:30 AM | | |
| 3. SEX FEMALE | 4. RACE WHITE | 5. DATE OF BIRTH MONTH DAY YEAR 3 15 1895 | | 6. AGE (IN YEARS LAST BIRTHDAY) 89 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD. | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH WORCESTER MD. | | | | |
| 10. CITY OR TOWN OF DEATH BERLIN, MD. | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BERLIN NURSING HOME | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) AT HOME | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE MD | | 13b. COUNTY WOR | 13c. CITY OR TOWN O. CITY | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS RT 1 21842 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST ROBERT J. HALL | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST DROSILLA SMACK | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO | | 16b. SOCIAL SECURITY NO. 216-38-9702 | | 17. INFORMANT ADDRESS H.W. HINDLE OCEAN CITY MD. | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 4409 IMMEDIATE CAUSE (a) <u>Cancer Resp Arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ASLD</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>AGING</u> | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Jan 83</u> to <u>May 84</u> 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>May 10</u> 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death. | | | | | | | | |
| 22b. SIGNATURE <u>Federico Arthes</u> M.D. | | | | DEGREE M.D. | | 22c. DATE SIGNED | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) FEDERICO ARTHEIS, M.D. | | | | 22e. ADDRESS 3 BAY STREET, BERLIN, MD. 21811 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 5/12/84 | | 23c. NAME OF CEMETERY OR CREMATORY SUNSET MP. | | 23d. LOCATION CITY OR TOWN COUNTY STATE BERLIN, MD. | | |
| 24. FUNERAL DIRECTOR NAME VLLRICH F.H. | | | | 25a. DATE REC'D. BY REGISTRAR MAY 16 1984 | | 25b. REGISTRAR'S SIGNATURE Lilia Davidson-Randall | | |

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Central Bank Branch
No. 100
Portland

March 13 1900
Portland, Me.

